



CHILD CARE BILLING REPORT
ND DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 616 (Rev. 10-2005)

Date of Service: (Month/Year)

Name of Parent:		Social Security Number:										Address:										Total Monthly Hours Worked Including Travel (To Be Completed By Parent)										Total Hours at School Including Travel Time (To Be Completed by Parent)									
Name of Provider:		Social Security Number/Tax ID Number:										Provider's Address:										Check if Change of Address										Telephone Number:									
How is Day Care Billed? (Check Method of Billing) Hourly Daily Weekly Semi-Monthly Monthly		Check Type of Child Care: TANF Program (JOBS, Employment, Pro-Work) Child Care Assistance Program Prime Time Crossroads Foster Care										Check Type of Care Provided (Letter on Provider Number): AR Approved Relative - (Q) RF Relative in Family Day Care - (F, I) SC Self Certified - (S) NG Group Care - (G, H) TR Tribal Registration - (R) CT Center -(C, E, K, M) NF Nonrelative in Family Day Care - (F, I)																													
Amount: \$																																									
Is this the last month you will be providing child care for this family? Yes No																																									

ENTER ONLY ACTUAL HOURS PROVIDED If **child** is sick (S) or on vacation (V) during the normal days of care, enter that code. (NOTE: These do **NOT** apply to provider's illness or vacation.)

	CHILD 1	Name:																						Age:				Total Hours:					Amount Due:				
	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
	HOURS																																				
	CHILD 2	Name:																						Age:				Total Hours:					Amount Due:				
	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
	HOURS																																				
	CHILD 3	Name:																						Age:				Total Hours:					Amount Due:				
	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
	HOURS																																				
	CHILD 4	Name:																						Age:				Total Hours:					Amount Due:				
	DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
	HOURS																																				

I hereby certify that the information, including the **actual hours** of care provided, on this form is true and complete to the best of my information and knowledge. I certify that both parties **signed and dated** the form after it was completed. I agree to promptly report to the county social service office any change or correction in the information shown on this form. I further agree that if this form or the parent listed is selected for field review, my signature below constitutes my consent to obtain verifying information from any necessary source. I certify that I have not billed this parent more than I billed private pay clients.

Total Amount Due:

Provider's Signature:		Date:		Parent's Signature:		Date:	
Provider Please Indicate:		Parents Please Indicate:		For Employed TANF Clients:		County Use:	
Are you registered/self certified? Yes No		Is either parent working? Yes No		Use Child Care Expense As (Check One)			
Are you licensed? Yes No		Is either parent in job search? Yes No		Expense Deduction in TANF Grant			
If you are an approved relative, have you been approved for these children? Yes No		Does either parent attending education/training have a bachelor's degree, an associate degree, certificate, or diploma? Yes No		Pay Child Care			

PARENT: Disclosure of the Social Security Number is voluntary and is requested for the purpose of accurate identification. Failure to disclose the Social Security Number will not affect participation in this program.

PROVIDER: Disclosure of the Social Security Number is required pursuant to 26 CFR 301.6109-1 and is requested for the purpose of reporting tax information. Failure to disclose this information results in a \$50 penalty under 26 CFR 301.6723-1 unless it is due to reasonable cause and not to willful neglect.

DISTRIBUTION: ORIGINAL: County Social Service Office

COPY: Child Care Provider

COPY: Parent

KEEP THIS STATEMENT FOR YOUR TAX RECORDS